

confirmed the diagnosis of donovanosis. A 6 week course of doxycycline 100 mg twice daily was commenced, and the patient made a full recovery.

In view of the increased transmissibility of HIV in association with ulcerating genital infections, an effective and acceptable oral agent is required for the treatment of donovanosis. Few well designed controlled trials have addressed this problem.² Effective treatment and prevention of ulcerating genital disease is important in the control of the spread of HIV. Clinicians investigating patients from tropical countries should be aware that trimethoprim and co-trimoxazole do not always eradicate donovanosis.

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Accepted for publication 12 February 1997

Perforation of hard palate in lues maligna associated with HIV infection

Unusual oral and skin manifestations of infectious diseases may be observed in patients with HIV infection.¹⁻³ These are quite often a challenge to the clinician. Destructive bone diseases such as osteitis and osteomyelitis are well known complications of congenital and tertiary syphilis; they are rare complications of early acquired syphilis.⁴ We report a case of perforation of hard palate in lues maligna associated with HIV infection.

A 30 year old promiscuous male presented with a solitary genital ulcer and recurrent erythematous nodules and ulcers over the

limbs (fig 1) and trunk for the past 5 months, associated with joint pains, swelling over the limbs, fever, headache, myalgia, and epistaxis. On further examination he had inguinal and epitrochlear lymphadenopathy. Oral examination revealed a mucosal patch and perforation over the hard palate (fig 2). Dark ground microscopy from the genital ulcer revealed several motile spirochaetes. VDRL was reactive in 1:128, TPHA and HIV (ELISA) were positive. Blood examination revealed normocytic normochromic anaemia with increased rouleaux formation, raised ESR (> 150 mm in the first hour). Liver function tests, antinuclear antibody (ANA), and double stranded DNA were within normal limits. The patient refused to undergo skin biopsy and lumbar puncture. In view of the clinical features, dark ground examination, and serological findings secondary syphilis (lues maligna) was considered. He was treated with procaine penicillin 24 units for 2 weeks. On follow up his skin lesions had healed.

The case is interesting because of early palatal perforation following lues maligna in this HIV patient. A review of the literature of the past 20 years revealed that of 1800 patients with early syphilis, less than 0.2% had evidence of periostitis, and there were no reports of destructive bone lesions.⁵ A recent review of bone and joint disease in association with HIV infection does not report syphilis related bone disease.⁶ Cases of HIV associated lues maligna with widespread, atypical ulcerations of the oral mucosa and skin have been reported.⁷⁻⁹ We postulate that defective cell mediated immunity might have facilitated the rapid dissemination of spirochaetes invading bones and joints resulting in bone destruction. Numerous spirochaetes observed in bone biopsy specimen suggesting the aggressiveness of syphilis in a patient with concurrent HIV infection has been documented earlier.¹⁰

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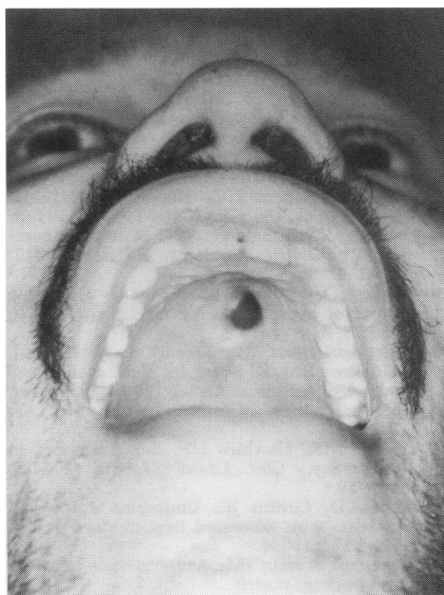


Figure 2 Perforation of hard palate.



Figure 1 Ulcers over the toes and few nodules over the dorsum of feet.

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Accepted for publication 12 February 1997

Sharing prescribing of continuous aciclovir treatment: effects of a new policy and general practitioner responses

Recent guidelines on the care of patients with genital herpes¹ include reference to improved communication between local genitourinary medicine clinics and general practitioners. This reinforces anecdotal reports that in some areas of the UK general practitioners and genitourinary medicine clinics were satisfactorily collaborating in the management of patients requesting continuous treatment with aciclovir.

In early 1996 the national reduction in HIV funding by 7.7% and the lack of designated additional funding for new antiretroviral drugs have resulted in extreme pressure on the drug budget within the directorate of HIV/GU medicine at the Chelsea and Westminster Hospital and prompted us to examine ways of extending collaboration with general practitioners with the secondary gain of achieving an overall reduction in our drugs budget. After discussion within the unit and with purchasers we attempted to reduce our projected deficit by restricting hospital prescribed therapies to treatments for HIV infection, and acute and new presentations of STDs. With the intention of preserving patient choice concerning confidentiality, however, we asked for our patients' specific consent to write to their general practitioners to request them to share responsibilities in the prescribing of continuous aciclovir for the prevention of recurrent genital herpes.

This policy took effect from April 1996, and during the following 5 months we approached 71 patients who were receiving regular prescriptions for continuous aciclovir to prevent recurrences of culture proved genital herpes from the genitourinary medicine clinic. Eight patients refused to have their herpes diagnosis and prescription needs disclosed to their general practitioners,